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ABSTRACT

The need for provision of recreation services tc the homebound aging has been reccgnized by many senior center organizers and directors. Because the attitudes and actions of both individuals and organizations are strongly affected by the social and cultural environment of their past, a history of both recreation and home-delivered services to the elderly is examined. Although neigher of these two areas has been studies definitively, existing data is presented. Secondary material draws from the literature examples establishing the need for such programs through study of the characteristics of the homebound aging, the benefits of recreation, and a rationale for coordinated service delivery. Because a survey of recreational services for the elderly shows little success in meeting homebound needs, and home-delivered services cffer little in the area of recreation, there is a need for programs in this area. (Author/LS)

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RECREATION FOR THE HOMEBOUND AGING

STATE OF THE ART

by

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RECREATION FOR THE HOMEBOUND AGING:

THE STATE OF THE ART

INTRODUCTION

The provision of recreation services to the homebound aging is not an idea unique to this project. The need for this service has been seen by many organizers and directors of senior centers and clubs whose members have been temporarily or permanently prevented from attending meetings by physical difficulties. This paper intends to summarize and evaluate the efforts made toward delivery of these services and provide a rationale for a coordinated approach to this long-standing problem.

Attitudes and actions of both individuals and organizations are strongly affected by the social and cultural environment of their past. Therefore, this paper begins with a history of both recreation and home-delivered services to the elderly in this country. As no definitive studies have been done in either of these areas, the following sections are a brief compilation of existing data.

Chapter 1

HISTORY OF RECREATION FOR THE AGING

The entire gerontology movement, including its component within the field of recreation, is a development of the last fifty years. Yet, the more distant past has strong implications for these disciplines which deal with a population born 10 to 40 years earlier. Kim and Wellons have described the expectations of the elderly during the agrarian period of our country as more agreeable than today's. A farmer living beyond the average 47-year life expectancy held a position of some importance. As a land owner and possessor of agricultural knowledge, he could expect to be deferred to and allowed to continue working as long as he desired.[1] In 1900, when only 4 percent of the population was over 65 years of age, a man could expect to be a productive worker up until 3 years prior to his death.[2] Although three-generation families were actually a rarity (only 3 percent of New York State Households in 1865), relatives were likely to settle nearby and frequent contact among extended families was the rule.[3]

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[1] Paul Kim and Kennard Wellons, Growing Old in the Bluegrass (Lexington: The Bluegrass Area Development District, Oct. 1974), p. 4.

[2] Seymour Wolfbein, "The Changing Length of Working Life," Mass Leisure, ed. Eric Larabee and Rolf Meyersohn (Glencoe, Ill : Free Press, 1958), p. 158-9.

[3] Kim and Wellons, loc cit.

Supportive of the needs of this pioneering stage was the Protestant work ethic which placed a high priority on work and independence. Benjamin Franklin's maxim "God helps them that help themselves" achieved the status of a biblical injunction.[4] Rudquist warns that the effect of this association of recreation with "sinful idleness" cannot be overlooked in understanding the difficulty of some elderly persons with participation in recreation programs.[5] Charitable institutions of this period were also reflective of the work ethic. Poorfarms, the forerunners of nursing homes to which the indigent elderly were sent, were judged to be the penalty of the lazy or improvident whose own family could not or would not support them.[6] However, in spite of these attitudes some early clubs for the elderly were organized during this era in Boston (1870)[7], Salt Lake City

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[4] Benjamin Franklin, "Poor Richard's Almanac," 1757 in Familiar Quotations, 13th ed., by John Bartlett (Boston: Little, Brown and Company, 1955), p. 330.

[5] Birger, J. Rudquist, "Recreation Problems of the Aging," Recreation and Aging, (Los Angeles: California Commission on Aging, 1968), p. 113.

[6] Henry S. Curtis, "Almshouses, Poorfarms or Infirmaries," Planning the Older Years, ed. Wilma Donahue & Clark Tibbitts, (Ann Arbor: University of Michigan, 1950), p. 79-80.

[7] Jean Maxwell, "Purposes and Functions of Senior Centers," Recreation and Aging, (Los Angeles: California Commission on Aging, 1968), p. 113.

(1878)[8], and Pacific Grove, California (1888).[9]

The late 1800's also ushered in a period of industrial growth. Large numbers of families began moving into the cities to find jobs in the new factories. In such settings agricultural expertise lost its value, families became more fragmented, and factory jobs favored the young. The status of the elderly began to decline.

Bucher and Bucher report that at the same time the social welfare movement, of which recreation initially was a part, began to respond to the ills inherent in urgan life. Settlement houses, parks, playgrounds and recreational organizations began to develop, all with the emphasis of providing for the needs of urban youth.[10] For adults, work still remained the focus of life, and nonproductiveness of activities or persons bore a negative connotation.

A major turning point for both the recreational movement and gerontological interests came with the Depression of the 1930's. The effects of Federal job assistance programs on the recreation movement are described by Bucher and Bucher as providing jobs for recreation personnel, building new facilities and enabling small communities

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[8]Rex A. Skidmore, Morman Recreation in Theory and Practice: A Study of Social Change (Philadelphia: The University of Pennsylvania, 1941), p. 62.

[9]Mrs. A. M. G. Russell, "The Development of Recreational Programs for Older Adults," Recreation and Aging (Los Angeles: California Commission on Aging, 1968), p. 5.

[10]Charles A. Bucher and Richard D. Bucher, Recreation for Today's Society (Englewood Cliffs, New Jersy: Prentice Hall, Inc. 1974), p. 68-69.

to develop recreational programs.[11] Simultaneously a number of factors were converging to make the elderly more visible. Lower birth rates and medical advances increased the percentage of elderly persons. Shortened work weeks and mandatory retirement at 65, both aimed at providing more jobs, increased enforced leisure. Migration of people into urban areas concentrated the elderly into larger masses. The effects of the Depression on this vulnerable group consequently brought the problems of aging to the attention on society.[12] The Social Security Act of 1935 was an immediate result.

It was at this point that social welfare agencies, themselves acquiring a more liberal philosophy of the "helping process" through the Roosevelt years, began to provide services to the aging as a group.[13] The first community to provide recreation services was Cleveland, Ohio. There in 1939 the Benjamin Rose Institute, in connection with Western Reserve University School of Applied Social Work, began an Old Age Club. The first members soon changed the name to Golden Age Club. The following year another club was started in Cleveland at the Goodrich Settlement House. Woods gives the assessed benefits of these "clubs for aging persons" as improved mental and physical health, improved self-respect, and greater social interaction.

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[11] Ibid, p. 70-71.

[12] Jon Hendricks and C. Davis Hendricks, Aging in Mass Society, Myths and Realities (Cambridge: Winthrop Publishers,Inc., 1977), p.5-6

[13] Earl Kauffman, "New Perspectives on Aging and their Challenge to Professional Leadership," (Paper prepared for the Advanced Training Institute for Nursing and Retirement Home Administrators, Institute of Gerontology, University of Iowa, October 17, 1968).

Consistent newspaper coverage helped the idea of Golden Age Clubs to spread rapidly and in 1949 The Rose Institute assumed sponsorship of 15 existing clubs.[14]

By this time groups had also begun in other states. The New York City Department of Welfare in 1943 established the Hodson Center, which extended the weekly meeting concept to a daily meeting format with a variety of activities. This center established a membership of 700 within a five year period.[15] As evidence of its value and effectiveness, Dr. Howard Rusk reported a 50 percent drop in health care visits and a 90 percent reduction in mental hospital admissions among its members as compared with the rest of the elderly population.[16]

Another early example of a multi-purpose center was the Little House in Menlo Park, California. Established in 1949 by the Peninsula Volunteers rather than a social agency, it supplemented recreational activities with a counseling service and classes in nutrition and health care.[17] As with the Hodson Center, the professional staff of the Little House encouraged membership participation in adminis-

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[14] James H. Woods, Helping Older People Enjoy Life (New York : Harper and Brothers Publishers, 1953), p. ix-xii.

[15] Richard Kraus, Recreation Today: Program Planning and Leadership (New York : Meredith Publishing Company, 1966), p. 350.

[16] California State Recreation Commission, Recreation for Older People in California (Sacramento: The Commission, October, 1951), p.15.

[17] George France McCoy, "Changing Recreation Concepts Relating to Our Senior Citizens," Recreation and Aging (Los Angeles : California Commission on Aging, 1968), p. 23.

tering the program. Both of these highly successful centers are still in operation.

Rapid growth of the elderly segment of the population continued through the 30's and 40's, from 6.6 million in 1930 to 12.3 million in 1950.[18] With this growth came the development of scientific interest and research. Barron reports the formation in 1939 of three major research efforts, the American branch of the International Club for Research on Aging; the National Advisory Committee on Gerontology appointed by the Surgeon General; and the National Research Council's Committee on Aging. All of these groups received some assistance from the Josiah Macy, Jr. Foundation. In 1940 the medical profession established the Geriatrics Society followed in 1945 by the Gerontological Society formed to provide a multi-disciplinary approach to research.[19]

The results of this compilation of data on aging had its effect on the policy makers. By 1949 the Federal Security Agency (now the Department of Health, Education and Welfare) was sufficiently alerted to the magnitude of the effects of the elderly population boom that they sent copies of a Working Committee on Aging report to 400 key figures. Two years later the first Conference on Aging was convened

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[18] Kim & Wellons, op cit., p. 10.

[19] Milton L. Barron, The Aging American (New York: Thomas Crowell Co., 1961), p. 5-7.

in Washington.[20]

That the recreation profession was aware of the needs of this age group was evident in the increasing numbers of articles published in their Recreation journal. The entire May 1949 issue was devoted to this new emphasis. Approximately 100 delegates participated in the Section on Creative and Recreational Activities of the 1951 Conference on Aging. Though recognizing that an emphasis on youth was common in existing community recreation programs, they pointed to: 1) the value of recreation for older adults, 2) the necessity for varied programs to encompass the great variety of needs and interests among this age group, 3) the variety of possible service agencies which might cooperate in this area and 4) the need for establishing professional standards for the increased recreational personnel to be required by these programs. The handicapped and homebound were especially noted as an important group for consideration. Suggested methods of serving the homebound were the use of friendly visitors and provision of radios, reading materials and movies.[21]

Conference delegates also considered the plight of the institutionalized elderly. The rapid changes in society and medicine which affected other aspects of society had produced a sudden change in the characteristics of the institutionalized populations. With the urbanization of society, families no longer had the space, income or man-

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[20]Federal Security Agency, Man and His Years (Raleigh, North Carolina: Health Publications Institute, Inc. 1951), p. 7-8.

[21]Ibid, p. 181-203.

power to care for chronically ill or disabled parents. When the need for even limited supervision arose, congregate care seemed the only alternative. Institutions established for small groups of indigent clients struggled to reorient themselves to this new influx of clients from varying backgrounds and in varying degrees of health.[22]

The 1950 Amendment to the Social Security Act required that the states enact and enforce minimum standards of maintenance and operation for all public and private facilities in which public assistance recipients received care.[23] Recommendations for the development of these standards which called for inclusion of recreation therapy, were voiced by the 1951 Conference Section on Health Maintenance and Rehabilitation. As a result the National Social Welfare Assembly's National Committee on Aging (now the National Council on Aging) published a series of guides on standards for domiciliary care in 1953 and 1954.[24] By 1960 all states had such regulatory laws but evidence showed they were not enforcing them.[25]

Recreation programs in institutional settings had always been the exception. A review of recreation programs in the October, 1933

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[22]"Special Situations," The Philosophy of Recreation for the Aging (Raleigh: North Carolina Recreation Commission, November, 1957), p. 34-5.

[23]U.S. Congress, Senate, Committee on Labor and Public Welfare, Subcommittee on Problems of the Aged and Aging, The Aged and Aging in the U.S.: A National Problem,(Washington: Government Printing Office, 1960), p. 138.

[24]Federal Security Agency, op cit, p. 118, 303.

[25]U.S. Congress, loc cit.

edition of Recreation highlighted a few good programs in the then 1,?68 nursing homes.[26] A 1954 conference on Recreation and the Aging commented that "the recreation program of any institution reflects the philosophy of its management."[27] The validity of this statement became more apparent when a 1958 survey by the National Recreation Association showed that only one percent of proprietary nursing homes had professionally directed recreation programs,[28] and a 1970 survey by Peters and Verhoven found no qualified activity directors in any of 109 Kentucky extended-care facilities.[29]

Recreation for the aging was an established area in the profession after 1950. Conferences on philosophy, programming and leadership training were held in North Carolina and California. Gerontologists from other fields began to look at leisure participation as a factor in aging research.[30] Senior centers and clubs developed slowly. The 1953 Yearbook of the National Recreation Association reported 392 cities providing programs for the aging.[31] The staffs of these

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[26]Erma D. Burke, "Too Old to Live," Recreation, 27:336-7, 349-50, October, 1933.

[27]"Special Situations," loc cit.

[28]Beatrice Hill, "What's New in Recreation for the Ill and Handicapped?" American Recreation Annual, 1960, p. 12.

[29]Martha Peters and Peter J. Verhoven, "A Study of Therapeutic Recreation in Kentucky Nursing Homes," Therapeutic Recreation Journal.

[30]Matilda W. Riley and others, Aging and Society, Vol. I, An Inventory of Research Findings (New York: Russell Sage Foundation, 1968).

[31]Marion Preece, "An Overall Picture," The Philosophy of Recreation for the Aging (Raleigh: The North Carolinia Recreation Commission, November, 1957), p. 8.

early programs were assisted by the appearance of the first books in the field: James Woods' description of social club programming, Helping Older People Enjoy Life (1953); Juliette Arthur's How to Help Older People (1954), which covered the first years of the Hodson Center; Arthur Williams' first programming guide, Recreation for the Aging ; and Robert Kleemier's edited collection of theoretical writings on Aging and Leisure (1961) .

Another innovation in recreation programming came in 1960 with a National Recreation Association project directed toward the homebound. One-half of the 84 clients referred from the Bellevue Hospital Home Care Division and the Visiting Nurse Service of New York were over the age of 60. The goal of the two-year project, funded by the Office of Vocational Rehabilitation, was the advancement of homebound individuals through sheltered group activities into full participation in community recreation. Although successful in this regard with many of its clients, the project did not result in widespread service to the homebound.[32] A similiar program in Chicago in 1963 did evolve into an on-going program for the handicapped (see page 24), but the homebound elderly remained virtually unnoticed by the recreation profession in general.

With the experience gained during the developing period of the 50"s, guidelines for services were developed and changed. While the

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[32]Morton Thompson, Meeting Some Social-Psychological Needs of Homebound Persons Through Recreative Experience (New York: The National Association, 1962), pp. 2,3,19, and 29.

emphasis of the first program in Cleveland had been in keeping the elderly occupied and providing social outlets,[33] by the time of the White House Conference on Aging in 1961 it had shifted to increasing senior participation in society. Senior centers were encouraged to be multipurpose, involved not only in creative and social activities, but in outreach, continuing education and service opportunities.

Whereas the 1951 Conference provided goals and objectives but no funding, the 1961 White House Conference resulted in major social legislation. The Older Americans Act of 1965 put into law ten objectives reflecting the recommendations of the 1961 Conference. These objectives included the "pursuit of meaningful activity within the widest range of civic, cultural, and recreational opportunities."[34] Title III of this act provided for state agencies on aging which would fund social projects. At its height, Title III was funding over 1,000 projects many of which were Senior Centers. Amendments in 1967 and 1969 increased the scope of Administration on Aging programs and a year after the 1971 White House Conference came the addition of Title VII legislation.[35] The Nutrition Centers set up under this

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[33] James H. Woods, Helping Older People Enjoy Life (New York: Harper and Brothers Publishing, 1953), p.13.

[34] "Federal Action for Aging Began in 1930's : What Has Happened Since " Aging, No. 247: May, 1975.

[35] Ibid, pp. 14-15.

program encouraged recreational activities at congregate meal settings.

The Older Americans Act as amended through 1973 has provided the greatest impetus for growth in recreational services for the aging. As an example, Senior Centers have expanded from 340 centers in 1966 to nearly 5,000 in 1976.[36] Only slightly less important has been the Social Security legislation of the 1960's and 70's which set up requirements for activities programs in nursing homes receiving Medicare funds. The continuing capability of the Federal Government to create services where there is funding will no doubt shape the future growth of recreation in the field of the aging. Current emphasis is turning toward alternatives to institutionalization. Increased funding is being encouraged for supportive services, including home-delivered services, which will allow the "frail elderly" to remain out of nursing homes. It is in this new area that recreators will be asked to design and deliver services.

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[36]William R. Pothier, "National Institute of Senior Centers Emphasized Standards for Programs," Perspectives on Aging, 4:26, September/October, 1975.

Chapter 2

HISTORY OF HOME-DELIVERED SERVICES

The current interest in alternatives to institutionalization is an interesting reversal of a trend away from home-delivered services, which began in the first quarter of the twentieth century. Although there have continually been experiments with home care, service delivery to the aging has focused, until recently, upon institutional care. A review of these early models and the influence of previously mentioned social changes may clarify the present situation. In general, there have been three major areas of home-delivered service: 1) homemakers which concentrate on home management activities, 2) home health care services which are physician-directed, and 3) visiting nurses which are public health-oriented.

Bergman described the first two centuries of home medical care in the U.S. He found that the Boston Dispensary provided home care for the indigent, as an alternative to more expensive institutional or out-patient care, as early as 1796. In 1875 Boston University School of Medicine and Massachusetts Homeopathic Hospital developed a home care service as part of the educational program for senior medical students. Both of these programs existed during a time when hospitals were essentially used only for the indigent, highly contagious, mentally ill, or those requiring extensive surgery. For the upper or middle class, births, tonsilectomies, and other minor

surgery, not to mention convalescence, took place in the home.[1] According to Fitzpatrick, visiting nurses were sometimes available to assist with illness or convalescence in the home. In 1886 the Boston Instructive District Nurse Association and the Visiting Nurse Society of New York City were formed. Both of these autonomous voluntary groups, as well as the Chicago Visiting Nurse Association, founded in 1889, were concerned with educating the public as to proper health practices as an adjunct to direct nursing care. By 1890 there were 24 similiar associations, most with only one nurse, and in 1905 there were 171 associations in 110 communities employing 445 nurses. Most outstanding of these was the Henry Street Nurses Settlement established in 1893 by Lillian D. Wald, pioneering leader of the "public health nursing movement." Her nurses lived in the slum area they were serving and provided a sliding fee scale to avoid the stigma of charity. Miss Wald was instrumental in organizing the first training program for public health nurses through the Department of Nursing and Health at Columbia University in 1907 and the Metropolitan Life Insurance Company's visiting nurse program for its policyholders in 1909.[2]

Medical advances during the early 1900's initiated a change in

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[1] Sidney M. Bergman, "Background Developments of Home Care," Selected Papers from Workshops and Institutes: Home Health Services (Pittsburg: Montefiore Hospital Association of Western Pennsylvania, 1970), p. 3-4.

[2] M. Louise Fitzpatrick, The National Organization for Public Health Nursing, 1912-1952: Development of a Practice Field, (New York: National League for Nursing, 1975), p. 7-8.

this home-oriented approach. The introduction of more complicated medical techniques and aseptic methods made hospitals the preferred delivery point for medical care.[3] In addition, improved public health lowered the incidence of acute disease. Consequently, life spans increased and permitted the increase in chronic disease. The effects of these changes in health conditions drew the attention of the early social welfare movement just as recreational needs had done. The removal of ailing mothers to the hospitals led social welfare agencies to provide "homemakers" to care for children in homes where the mother was absent.[4] In 1923 the Jewish Family Welfare Society of Philadelphia established the first organized homemaker service. A second service was formed the following year by the Jewish Home Finding Society of Chicago.[5] Other metropolitan agencies did the same during the 30's. In 1933 the Chicago Welfare Department began including home care as part of their new medical component.[6] The National Association of Public Health Nurses, organized since 1912, had now developed into the the primary unit of the visiting nurse service with 3,267 agencies.[7]

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[3]Cecil G. Sheps and Jack Kasten, "Home Care Programs," Rehabilitation Literature 23: 130-135, May, 1962.

[4]Eugene Shinn and Nancy Robinson, "Trends in Homemaker-Home Health Aide Services," Abstracts for Social Workers, 1974, 10, p.5.

[5]Ibid.

[6]Bergman, op.cit., p.5.

[7]Catherine Tinkham and Eleanor Voorhies, Community Health Nursing (New York: Meredith Corporation, 1972), p. 54.

The Depression years, as has been recorded, had an especially severe effect upon the elderly. A National Health Survey of 1935-6 showed the nation's number one health problem to be chronic disease, partially as a result of the increased elderly population.[8] As an indicator of the government's concern, the Social Security Amendment of 1935 provided funds to expand health nursing programs within the states.[9] According to Shinn and Robinson, the homemaker service also received a boost during this period from the Works Progress Administration in the form of a housekeeping-aides program. Although intended as "mother replacements" some agencies initiated the use of these aides with the elderly and chronically ill. Federal assistance was discontinued in 1942 and the need for factory workers during the war years curtailed the expansion of this program for a short while, although its worth had been established.[10]

The end of the war was also an important time for the development of home health services. The expense of hospital care and the need for more efficient use of bed space led to a study in 1945 by Dr. E.M. Bluestone for the Jewish Philathropies in Pittsburgh. He recommended home care because it was a less expensive alternative for the chronically ill and it freed hospital beds for the acutely ill who could not be treated at home. Bluestone also provided the first

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[8] Thomas Parrau, "Mobility and Mortality in the United States," Annual Report of the Surgeon General of the Public Health Service (Washington: Government Printing Office, 1939), p. 20.

[9] Tinkham and Voorhis, op. cit., p. 89.

[10] Shinn and Robinson, loc. cit.

definition of coordinated home care: " Home care requires medical visits as necessary; visiting nursing; visits for the application of the special therapies, and above all, good medical social services."[11]

Three years later Dr. Bluestone directed the first hospital-directed program based on his recommendations at the Montefiore Hospital in New York City. A basic team consisting of a physician, a nurse, and a social worker, all of whom were employed by the hospital, delivered services to the homebound. Other team members could include physiotherapists, speech therapists, and occupational therapists. The majority of the people served were over 65 years of age and suffering from such illnesses as stroke, arthritis, cancer and heart disease. This program was effective in demonstrating that treatment could take place in the home setting and that home care could prevent rehospitalization and shorten hospital stays.[12] The following year, in 1949, a similar program was developed at the Michael Reese Hospital in Chicago. The basic responsibility for its operation was vested in two homes for the aged whose personnel screened applicants to determine whether they could be better served in their own homes. Recreational activities were provided at the homes for the aged to which clients in the program could come.[13]

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[11] Bergman, op. cit., p.6.

[12] J.C. Brocklehurst, ed. Geriatric Care in Advanced Societies (Lancaster: M.T.P., 1975), p. 105.

[13] Morris, op. cit., p.v.

The period of the 50's was one of gradual proliferation of services to the homebound. From 1950 to 1958, homemaker services more than doubled.[14] Voluntary nursing agencies and hospital-administered programs expanded more slowly.[15] It was not until the advent of Medicare in 1965 that significant new trends began to develop in home-delivered services.

As Moore explains, Titles XVIII, XIX, and XX of the Social Security Act provided for certified "home health agencies" to deliver certain physician-prescribed services. With the availability of these funds there was a growth of qualifying agencies from 1,275 in 1965 to 2,311 in 1970 before the narrowing funding interpretations reduced the numbers somewhat. A shift of auspices has also occurred, with visiting nurse associations providing only 22 percent of the qualifying home health services in 1976 as opposed to 61 percent in 1963. Official health agencies increased from 33 percent of service delivery to 51 percent. An influx of proprietary agencies has also begun to appear. In general, the shift has been from the voluntary to the public sector. In addition, the clientele served by these agencies has shifted from families with children to the predominantly elderly.[16]

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[14] Shinn and Robinson, op. cit., p. 6

[15] Claire F. Ryder, Pauline Still and William F. Elkin, "Home Health Services-Past, Present, Future," American Journal of Public Health 59: 1720, September, 1969.

[16] Florence M. Moore, "New Issues for In-Home Services," Public Welfare, 35: 29-31, Spring, 1977.

Coordination of services is being encouraged through examples such as the Association of Home Care Agencies in Cincinnati, Ohio described by Mootz. In an effort to improve conditions of inadequate funding, gaps in service, and referral inadequacies, a coalition of 12 home care agencies was developed. Since its inception in 1972, this group has developed a directory of 500 resources for in-home care in the Cincinnati area, established a one-number, centralized intake system, and developed extensive cooperation among voluntary, public, and proprietary agencies, hospitals and physicians.[17]

The future of in-home services will be greatly dependent on the direction of federal funding, particularly in the long-term health care area. The liberalization of conditions for Medicare reimbursement for these services may be the next step. To be ready for a greater demand for in-home services, efforts towards coordination and expansion of programs must be emphasized.

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[17] Ann Mootz, "Homemaker Service in a Coordinated Home Care Program," a paper presented at the Management Institute conducted by The National Council for Homemaker-Home Health Aide Services, April 15, 1977.

Chapter 3

SURVEY OF EXISTING HOMEBOUND RECREATION PROGRAMS

It should be apparent from the previous discussion that recreation services for the aging have been concentrated in congregate settings such as nursing homes and senior centers, while services for the homebound have been following a medical model. Funding sources have encouraged this trend, leaving voluntary agencies to provide the minimal social outlets of "meals on wheels", telephone assurance, or friendly visiting. A clear picture of the service gap is indicated by the following survey of existing recreation programs.

Leisure delivery systems that reach out to the homebound have been organized in several locations throughout the United States. These programs tend, for the most part, to serve physically disabled persons of all ages as well as those whose mobility is restricted for economic or social reasons. They may be exclusively recreation-oriented service systems or programs that include recreation services as part of other encompassing concerns. In many cases they are offered as an extension of a single center program and in others as an element of a decentralized, multi-service program. And while recreation services may be offered within the home, the predominant characteristic of such service is taking persons out of the home in order to engage in programs conducted either in a center or in the community.

One of the most extensive programs is directed by the Recreation Center for the Handicapped in San Francisco. Developed by Janet Pomeroy in response to the needs of mentally retarded and physically

handicapped individual the center provides programs six days a week, meals, and transportation both to the facility and to outside activities. In 1970 an outreach program was established to serve the severely handicapped in their own homes. In 1974 this program was expanded through an Administration on Aging grant to serve the elderly as well. This outreach program consists of weekly visits of one hour to the homebound individuals by volunteers with hobby or other recreational materials, and the provision of transportation for those able to travel. There is little effort to provide services not associated with recreation although referrals are made as necessary. Funds come from a variety of sources, including the municipal recreation department, the Community Mental Health Service, and the Department of Social Services, as well as solicitations.[1] This year approximately 120 aging persons were served in their homes.

The Franklin County Council on Aging, Inc. of Frankfort, Kentucky operates a Senior Citizens Center which is the focal point of all problems and activities of the senior citizens in Frankfort and Franklin County. The main center, which houses the administrative offices, is located in the accessible basement of a downtown hotel. Services are also provided at a number of other locations including two downtown churches. A strong outreach program, staffed primarily by elderly volunteers provides home-delivered meals, mobile library ser-

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[1]Janet Pomeroy, "A Proposal to Provide Outreach Socialization Programs for the Elderly Who Are Isolated from Their Community to Sustain Their Mental and Physical Functioning," San Francisco: Recreation for the Handicapped, Inc., 1974, n.p.

vices (including materials for the blind), home chores, newsletters, recreation and craft activities, home health nursing, and adapted transportation. Financial support comes from the Bluegrass Area Development District, the United Way and the city and county governments.[2]

A mobile service is offered by Southeastern Virginia Areawide Model Program, Inc. (SEVAMP) of Norfolk, Virginia, a linking and co-ordinating agency that has grown out of a Senior Center in the Tidewater area. Its administrative offices are located separately from the senior centers and are funded under the Older Americans Act of 1965. In addition to the centers there are two mobile units which operate mainly in rural areas.

> These mobile vehicles are large, driver enclosed campers with stove, refrigerator, tables, seats, etc. Some small group programming, i.e., group meetings, arts and crafts, is done in the mobile units. The units also serve as office and consultation facilities for health, social service, recreation and vocational rehabilitation counselors who from time to time ride in them. The drivers of the mobile units also do outreach, fill out forms for the information and referral center and carry out social and recreational activities. The Home Demonstration agents, through Virginia Polytechnical Institute, provide a nutrition education program in the mobile units.[3]

The major function of SEVAMP is information, referral, and follow-up through the use of a computer in Hampton Roads. Data on 26 services can be used by anyone or any agency in the area. Follow-ups are conducted after two weeks to see if services were received.[4]

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[2]Talmadge Fowler, Alternatives to the Single Site Senior Center (Washington, D.C.: National Council on Aging Inc.), 1974, pp. 19-22.

[3]Ibid., pp. 41-43. [4]Ibid., pp. 41-43.

The Homebound Program of the Chicago chapter of the National Multiple Sclerosis Society was begun in 1963 as a one-year demonstration project of the National Recreation Association. It has continued under the auspices of the Chicago chapter with the support of the community. Although initial activities were conducted in the clients' homes, this program now emphasizes community activities for the disabled adults in four counties with classes, field trips, camping and social activities.[5]

An after-care program is offered to selected patients by the Younkers Memorial Rehabilitation Center in Des Moines, Iowa. Referrals are made by the staff psychiatrist and the type of services offered vary with patient needs. The recreational therapist provides leisure counseling and coordinates visits by volunteers to assist the patient in carrying out activities. A physical therapist, speech therapist, public health nurse and medical social worker are also available.[6]

The North Kingston, Rhode Island, Multipurpose Senior Center, funded by the town of North Kingston and the Rhode Island Division of Aging provides a variety of recreational, referral, counseling, and health-related activities. It also has 3 outreach workers on

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[5]"History and Background of the Homebound Program, Chicago Chapter, National Multiple Sclerosis Society," (Chicago Chapter-National Multiple Sclerosis Society, 1977), n.p. (Mimeographed)

[6]Personal conversation with recreational therapist, Younkers Memorial Rehabilitation Center.

its staff who deliver some recreational materials to 50 homebound individuals and some 350 elderly who are lacking transportation.

The Nassau County, Long Island, Recreation Department began a homebound recreation program in 1971 through its Senior Citizens Unit. An attempt to canvass homes led to the identification of 140 homebound individuals. Volunteers were recruited, trained and matched with homebound clients. During the first three years of operation only 10 volunteers participated. Two years later there were 30 to 35 volunteers and 3 outreach workers, who continued the search for homebound clients. Initial goals of the program included publication of a newsletter once a month, social events and eventual mainstreaming into the community. An extension of the program now includes a 20-member organization of Nassau county agencies entitled CACHES- Council of Agencies to Coordinate Homebound Services- with a homebound hotline. Many of the persons served are not entirely incapable of leaving their homes, but may only be psychologically unready.[7]

The Visiting Nurse Association of Minnehaha County, South Dakota received a three year Administration on Aging grant to develop a craft-mobile for use by their homebound clients. Craft supplies are delivered to the home approximately once a week for the purpose of occupational therapy, mental stimulation and companionship with a worker. Educational and information referral components have also been added.

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[7]Angela Robinson, "Seeking Out the Homebound," Newsday (Long Island, New York), October 18, 1977.

This service is currently funded by the city of Sioux Falls.[7]

A field test of the Kentucky department of Human Resources' Department Project Independence is now taking place in the eight county Purchase Area Development District of Kentucky. This program seeks to assure a degree of organization among agencies assisting the elderly so that all necessary services will be provided that enable aging individuals to remain in their own homes. A spectrum of 24 vital services is required, including recreation. The two-year experimental project will provide information on the feasibility of a concentrated program to provide the elderly with an alternative to institutionalization.

This brief description of programs is a result of a careful survey of the literature and the persons working in this field. The paucity of information is representative of efforts to make recreation available to the homebound in general. The remainder of this paper will highlight the need for recreation services among the homebound aging and offer suggestions for a feasible means of delivering these services.

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[7] Patricia Eggers and Barbara Jurgens, "Applications for Craftmobile Project," Sioux Falls, S.D.: Minnehaha County Visiting Nurse Association.

Chapter 4

ESTABLISHMENT OF NEED

Characteristics of the Homebound Aging

In attempting to identify the characteristics of the aging population, we first must determine what constitutes old age. Defining the term "older" person is not an easy task although "biologists agree that almost as soon as an organism stops growing, it begins the process of growing old."[1] Another way to define aging is through various forms of measurement. Chronological age, for instance, is calendar age or the measurement of age according to years and months. A second way to measure age is by looking at an individual's life course. Life course is the measurement of a person's age in relation to "a sequence of events that begins with birth and ends with death."[2] Atchley provides the broadest definition of aging in the following statement: "Aging, then, is a gradual process with relatively few changes and it varies, sometimes greatly, from individual-to-individual."[3]

The elderly are becoming an increasing proportion of our nation's population. According to the 1970 census, there are approximately

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[1]Robert C. Atchley, The Social Forces in Later Life: An Introduction to Social Gerontology (Belmont, California: Wadsworth Publishing Co., 1972), p. 6.

[2]Ibid.

[3]Ibid.

22 million identified persons aged 65 and over. Included in this group, are more than 10 million over 73 years of age; one million 85 or over; and more than 106,000 reported as being over 100 years of age.

These figures indicate that the aging account for approximately 10 percent of our nation's population. This shows a significant increase since the turn of the century. In 1900, those aged 65 and over accounted for approximately four percent of the population of the U.S. It has been projected that the aging will constitute 11.1 percent of the population by 1980.[4]

Although the aging have been categorized into the 65 plus age group it is important to look at two additional groups in reference to the homebound aging. First, 1974 statistics by the National Clearinghouse on Aging reported a little more than 10 million persons in the 60 to 64 age group. This brings the total for the 60 plus age group to around 32 million. The 75 years and over age group must receive special consideration since they are more likely to have infirmities that cause immobility. As age increases, the potential incidence of infirmity and immobility increases. 1976 census figures show 8,449,000 persons age 75 and over. The projected increase for the year is to 13,521,000.[5]

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[4]Atchely, op cit, p. 9.

[5]U.S. Congress, Senate Committee on Nutrition and Human Needs, The Homebound Elderly: The Need for a National Meals-On-Wheels Program, 94th Congress, Nov. 1976 (Washington: U.S. Government Printing Office, 1976), p. 5.

There are many problems facing the aging person in America today. Although these are not unique they are magnified in relation to age. Inadequate income constitutes the major problem for the aging. "...15.7 percent or 3.3 million persons aged 65 and over are below the poverty level... 32% of the elderly persons living alone are below the poverty level."[6] According to Butler:

> it is important to know that the poverty among older people is a poverty that came as a consequence of growing old. Poor older people are older people that grew poor, as well as poor people who have grown older.[7]

Mandatory retirement and being forced to live on a fixed income have magnified this problem.

Health problems weigh heavily on our aging population. Butler and Lewis point out "Few people in the United States can think of old age as a time of potential health and growth."[8] Chronic diseases, long-term illness, and disability comprise the bulk of these health problems faced by older Americans. "Statistics indicate that as life expectancy increases due to better control of infectious disease and advances in medicine, the problem of chronic disorders in the aging

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[6]U.S. Dept. of Health, Education and Welfare, Facts About Older Americans 1976, DHEW Publication No.(OHD) 75-2006 (Washington: U.S. Government Printing Office, 1976).

[7]Robert M. Butler, "Remarks on Aging," paper from NIA Open House Speakers Forum (Bethesda, Md.: National Institute on Aging of the National Institute of Health, May 1, 1976), p. 4.

[8]Robert N. Butler and Myrna Lewis, Aging and Mental Health - Positive Psychological Approaches (St. Louis: The C.U. Mosby Co.,1977) p. 17.

population also increases."[9] Nearly 90 percent of the elderly have one or more chronic health problems.[10] Perhaps one-half of the over $117 billion spent in health care by Americans in 1975 was in the area of chronic disease and two-thirds of every Federal dollar spent in health was spent in the 65 and over population.[11]

"The availability of services is another vital issue which is at the base of many of the problems of older people."[12] The key to this problem is transportation. Many older Americans no longer drive a car and effective public transportation is limited. In 1972, 60.8 percent of the population aged 65 and over were limited in activity and/or mobility.[13] Since there are no comprehensive home services available to the aging, transportation is vital, and yet, still limited.

Social isolation is another common problem that must be dealt with by many aging persons. "In the United States the overwhelming majority of older persons face a prevailing sense of being put on a

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[9]Charles D. Bonner and Freddy Hombuger, Homburger and Bonner's Medical Care and Rehabilitation of the Aged and Chronically Ill, 3rd ed. (Boston: Little Brown and Co., 1974), p. 141.

[10]Butler and Lewis, op. cit. , P. 21.

[11]Butler, op. cit., p. 6.

[12]Butler, op. cit. , p. 4.

[13]Public Health Service, Health Resources Administration, Limitations of Activity and Mobility Due to Chronic Conditions, Vital and Health Statistics - Data from the National Health Survey, Series 10, No. 96, Department of Health, Education and Welfare (Rockville, Maryland: National Center for Health Statistics, November, 1974), p. 5.

shelf and forgotten after age 65."[14] Mandatory retirement, Social Security regulations, changes in family roles, as well as many other social changes, in combination often lead to isolation among the aging. With the loss of an employment role, lowered income, and the fading of the extended family, boredom and loneliness frequently result.

Other problems facing the aging in our society include malnutrition, often due to inadequate income and loneliness, and mental health-related problems. Twenty-five percent of all suicides committed in the United States are committed by people 65 years of age and older. In addition, there is the major problem of crime against the elderly. This is a highly vulnerable population, which is often victimized, not only by brutal crime, but also by consumer fraud and manipulation.[15]

"The homebound or 'shut-in' elderly share most if not all of the same characteristics as the general elderly population in addition to their immobility."[16] In a 1976 study by the Senate's Select Committee on Nutrition and Human Needs, the homebound were found to include: 1) the physically handicapped, 2) the mentally incompetent, 3) temporarily incapicated Title VII participants, 4) other convalescents, 5) isolated rural residents, 6) the transportation deprived, or 7) those physically incapable of preparing their own meals.

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[14] Butler and Lewis, op cit, p. 23.

[15] Butler, op cit, p. 7-8.

[16] Select Committee, op cit, p. 5.

According to a National Health Survey by the Public Health Services of the U.S. Dept. of Health, Education and Welfare in 1972, an estimated 25,868,000 persons, or 12.7 percent of the population (civilian and non-institutionalized) suffered from activity limitations due to chronic disease or impairment.[17] Six million, four hundred fifty-eight thousand persons, or 3.2 percent of the population were reported to have mobility limitations due to chronic conditions.[18] Of those with mobility limitations, 5,960,000 were also reported as having activity limitations and 1,775,000 were homebound.[19]

The highest percentage of activity and mobility limitations occurred in persons living alone (13.4 million people). The aging are the primary members of this group.

> Of particular interest in these data is the substantial numbers of persons who are living alone and unable to carry out major activities (6.6 percent of 13. 4 million persons) and of those confined to the house (2.6 percent of the total). A majority of the persons contributing to these rates were people 65 years and over.[20]

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[17]"Limitations of activity is defined as the inability to carry out the major activity of one's age-sex group, such as working, keeping house or going to school, restriction in the kind or amount of major activity, or restriction in relation to other activities such as recreational, church, or civic interests."

[18]"Limitation of mobility is defined as restriction in ability to move freely; this ranges from confinement to bed all or most of the time to having trouble getting around alone."

[19]Public Health Service, op cit, p. 1.

[20]Ibid, p. 8.

In the 65 and over age group, 43.2 percent suffered activity limitations,[21] and 17.6 percent suffered mobility limitations. Of the 1,775,000 that were homebound, 1,028,000 were 65 and over. The portion of homebound aging not confined to the bed was 4 percent and those confined to the bed equalled 1.2 percent.[22]

A comprehensive study of 349 home-delivered meal programs was conducted in 1972 by Holmes and Howell at the Center of Community Research in New York City. Thirty-two of these programs were used for intensive study. Sixteen participants from each program were interviewed. Of these, approximately 74 percent lived alone, one-half had incomes of less than $2,000 a year, and only 10 percent had incomes of $5,000 or over. The findings of this study revealed that 19 percent suffered from general infirmities of old age; 14 percent from ambulatory problems; and 12 percent were crippled or bedridden. In addition, eleven percent were recovering from surgery or illness; eight percent had poor dietary habits; seven percent had heart problems; seven percent had arthritis; senility accounted for five percent; blindness for five percent; diabetes for five percent; and six percent had mental illness or need for companionship.[23]

A similar study was conducted in 1971 at the Neighborly Center,

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[21] Ibid, p. 6.

[22] Ibid, p. 21.

[23] Select Committee, op cit, p. 12-13.

Inc. of St. Petersburg, Florida. This study investigated the Meals-On-Wheels project and was partially funded by a Title IV grant from the Administration on Aging. The participants ranged in age from 60 years to 96 years with a mean age of 80.4 years. Sixty-six percent had monthly incomes of between $100 and $199 with 94 percent reporting Social Security as their primary source of income. The total average monthly expenditures by the participants was $117.80 The physical conditions displayed were consistent with the Holmes and Howell study. Additional findings revealed that one-half of the participants had poor vision (even with glasses), 24 percent were partially blind, 20 percent were hard of hearing, 82 percent used dentures, 47 percent had the ability to walk only with help, with one-fourth needing a crutch to walk, and 89 percent were unable to climb stairs.[24]

Several individuals and organizations have attempted to estimate the numbers of homebound aging in the U.S. The Select Committee on Nutrition and Human Needs of the U.S. Senate in 1976 reported that, "more than three million Americans over the age of sixty are currently homebound and are unable to provide for their own meals."[25] According to Rudolph T. Danstedt, assistant to the President of the National

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[24] Ibid, p. B.

[25] Ibid, p. 14-15.

Council of Senior Citizens in a testimony before the Subcommittee on Health and Long-term Care of the House Select Committee on Aging in November, 1975:

> We are beginning to face up to the fact that somewhere on the order of one out of six older Americans who are not in institutions are in need of direct health and social services if they are to be able to manage their own affairs and remain in their own homes and communities.[26]

If we use Danstedt's figures of one in six older Americans, the number of homebound aging would be somewhere around three million. Dr. Robert Norris and staff specialists of the Levinson Gerontological Institute of Brandeis University estimate that 16 percent or 2.9 million non-institutionalized aged were homebound in 1975. Agnes Brewster, a consultant to the Senate Special Committee on Aging estimated that 2.6 million persons aged 65 and over needed in-home services. Her figure is broken down into: 300,000 persons in institutions and 2.3 million persons located in the community.[27] Should we add Brewster's 300,000 estimate of institutionalized aged in need of home-delivered services to Norris' 2.9 million estimate in the community, the number rises to 3.2 million potential homebound aging. Finally, according to Ethel Shanas, "six percent of the non-institutionalized

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[26] Ibid, p. 1.

[27] Ibid, p. 14-15.

population over 65 was housebound in 1962, seven percent in 1975."[28] This comparison was based on surveys she conducted during those years.

> Clearly, the homebound aged suffer not only from the general problems facing most Senior Citizens, but also from a wide range of other physical and mental handicaps. It is these burdens which make this group the most dependent and most in need of companionship and assistance.[29]

The Benefits of Recreation

The degree to which recreational activities can alleviate the needs of the homebound has been the subject of considerable research which has implications for the delivery of leisure services to these individuals. The value of recreation experiences for the homebound elderly can be ascertained by studying the relationships among health, activity, isolation, and life satisfaction. As would be expected, the four are interrelated. Suchman found poor health, particularly self-perceived poor health, to be associated with reduced happiness as well as reduced activity.[30] Maddox, in two separate studies with similiar subjects found morale to be positively associated with high activity

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[28]"Annual Meeting of Gerontological Society Draws 200 Professionals," Aging, Nos. 268-269, February/March, 1977, p. 11.

[29]Select Committee, op. cit., p. 13-14.

[30]Edward A. Suchman, Bernard S. Phillips and Gordon F. Streib, "An Analysis of the Validity of Health Questionnaires," Social Forces 36:229, 1958.

rates and with self-assessed health.[31] A multiple regression analysis by Palmore and Luikert showed self-rated health to be the predominant variable affecting life-satisfaction, explaining more variability than all other factors combined.[32]

A secondary analysis of data from a longitudinal twin study be DeCarlo indicated that a pattern of regular recreation participation was significantly associated with successful aging. In studying the factors of this relationship, cognitive types of activities were found to be significantly related to physical health to the exclusion of activities in the affective or sensory-motor domains.[33] Riley found reduction of activity from former levels as well as low activity levels in general, to be associated with lower life-satisfaction ratings.[34] "Poor health and relative social isolation are two factors most closely associated with a sense of futility in old age" according to a study by Kunter. Nearly two-thirds of the isolated group he observed was in poor health, as opposed to one-half of the non-isolated.

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[31]George Maddox, "Some Correlates of Differences in Self-Assessment of Health Status Among the Elderly," Journal of Gerontology 17: 180-185, April, 1962; and "Activity and Morale: A Longitudinal Study of Selected Elderly Subjects," Social Forces 42: 195-204, October, 1963.

[32]Erdman Palmore and Clark Luikart, "Health and Social Factors Related to Life Satisfaction," Journal of Health and Social Behavior, 13: 68-80, 1972.

[33]Thomas DeCarlo, "Recreation Participation Patterns and Successful Aging," Journal of Gerontology 29: 416-22, July, 1973.

[34]Matilda W. Riley and others (eds.), Aging and Society, Vol. I, An Inventory of Research Findings (New York: Russell Sage Foundation, 1968), p. 353.

This led him to suggest that futility resulted from the combination of isolation and poor health, rather than from isolation alone.[35] A longitudinal study by Lowenthal indicated:

> reductions with aging in social activities were found to be consistently associated with low satisfaction only if connected with externally imposed deprivations (such as poor health, widowhood and enforced retirement). Of the two factors deprivations appear to be more closely associated with low satisfaction than does reduced activity.[36]

In Lowenthal's studym poor health was defined as a physical disability occuring in the last two years.

For the homebound elderly, this indicates a probability of poor health and confinement producing social isolation and reduced levels of activities, resulting in lower life satisfaction. A program of recreational activities aimed at increasing social contacts would apparently have more effect if associated with health care services. This is the pattern being followed at the day care centers in Lexington, Kentucky. A five-month study of participants there found a significant improvement in emotional functioning and interpersonal relationships.[37]

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[35]Bernard Kunter, et. al., Five Hundred Over Sixty: A Community Survey on Aging (New York: Russell Sage Foundation, 1956), p. 756-757.

[36]Marjorie Fiske Lowenthal and Deetje Boler, "Voluntary vs. Involuntary Social Withdrawal," Journal of Gerontology 17: 363-365,367, 1965.

[37]"The Centers for Creative Living" Lexington-Fayette County Health Department, Lexington, Kentucky. Unpublished pamphlet.

These seriously impaired older people are susceptible to "a kind of solitary confinement destructive to mental and physical health and to humanity."[38] Their contacts with the outside world are dependent on the willingness of others to bring that world to them. Physical limitations increase the stress of restricted sources of self-fulfillment brought on by a work-oriented society. Many former activities and roles have been involuntarily dropped from their lives due to circumstances of aging and poor health. Without assistance they may sit brooding over their physical condition, dependency, and the general feelings of uselessness. A downward spiral of further psychological and physical deterioration may begin as negative self-concepts are internalized and lack of stimulation continues.

Stopping this pattern requires positive efforts to recreate dynamic interaction between the homebound individual and society. Recreation can be the ideal medium for improving this level of interaction. Leisure activities can reawaken creative impulses, encourage social involvement, provide a sense of accomplishment and self-worth, and also ease the transition towards further interaction with the community. By the same token such transitions are further safeguards against the elderly being shunted off to institutions where the problems of inactivity begin anew.

Rationale for Coordinated Service Delivery

Providing leisure services to the homebound is no simple or

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[38] Let's End Isolation U.S. Department of Health, Education and Welfare (Washington: National Clearinghouse on Aging), preface.

easy task. It requires ideally, that professionally-trained personnel be enlisted to enter the homes of the aging to assist and counsel them in the satisfying and fulfilling use of their leisure time. The professional might provide them with materials for developing their interests in an activity such as painting or reading, teach them the skills needed to undertake a new activity such as block-printing or ceramics, or motivate them to attempt any number of activities that could appeal to their interests. There are a myriad of activities and ways of using one's leisure, even within the confines of the home, to make that time more satisfying and therefore enriching one's life materially.

However, in the face of the large numbers of homebound aging persons found in society, the ideal of professionally conducted individualized programs and contacts becomes somewhat unrealistic. If the homebound aging are to receive even minimal services related to recreation, it must perforce be on some basis that utilizes either paraprofessionals or personnel who are part of existing delivery systems. With this in mind, the attempt to inject leisure services into programs that currently reach out to the aging becomes a reasonable and acceptable approach.

In summary, the homebound aging represent a group in need of a variety of services in order to remain independent with maximum functional ability and minimal deterioration. Among these services is the opportunity for recreational activities which will provide social, creative, or service outlets. A survey of recreational services for

the elderly show little success in meeting the needs of the homebound, while home-delivered programs have shown little interest in providing recreational services. In rectifying this situation a coordination of efforts seems most appropriate. The National Council on Aging's NVOILA (National Voluntary Organizations for Independent Living for the Aging) Program makes the following statement:

> Any group offering or planning to offer services to older adults in their own homes should evaluate the multiplied effect of a cluster of services on the well-being of those served and concomitantly the economies-- in time, money, effort, staff -- of multi-service programs as contrasted with simple service operations.[39]

It is therefore postulated that a system of in-house recreation services delivered by properly trained staff of existing agencies, can provide a meaningful increase in life satisfaction for the homebound aging while allowing for an efficient use of time, manpower and money.

Such a joint effort can also provide the impetus for further cooperation among agencies to the benefit of the homebound and the entire aging community. The coordination of service delivery to the homebound is seen as a priority need by the National Council for Homemaker-Home Health Aide Services. While some older people need only one service to enable them to remain at home, most will need several and the combination of needs will change over a period of time.

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[39]Joyce C. Welsh, A Guidebook for Local Communities Participating in Operation Independence (Washington: The National Council on Aging, June, 1975), p. 20.

An actual merger of services or a single referral and clearinghouse for all in-home services is recommended in preparation for new patterns of Federal funding.[40] The program model suggested here will be an effort in the proper direction and in keeping with the Older Americans Act objectives to provide a system of coordinated and comprehensive services for older persons.

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[40]Florence M. Moore, "New Issues for In-Home Services," Public Welfare, 35: 31-36, Spring, 1977.

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